CHAPTER 73

CASE MANAGEMENT SERVICES MANUAL

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SUBCHAPTER 1 GENERAL PROVISIONS

10:73-1.1 Purpose and scope

(a) This chapter outlines information about targeted case management services provided by approved New Jersey Medicaid/NJ FamilyCare program providers.

(b) N.J.A.C. 10:73-2 describes the Case Management Program/Mental Health, providing a description of the individuals for whom the services are targeted; the case management services covered; the requirements and responsibilities of the agencies that will provide the services, including agency staff; the procedures required to provide services and the reimbursement for the provision of those services.

(c) N.J.A.C. 10:73-3 describes the care management organization services component provided under the Children's System of Care Initiative. The subchapter describes the target population to be served; services provided; and the requirements and responsibilities of the provider, including, but not limited to, the organizational structure, staffing, procedures, reporting requirements, monitoring, evaluation, and reimbursement requirements.

(d) N.J.A.C. 10:73-4 provides a listing of HCPCS Procedure Codes (HCFA Common Procedure Coding System).

10:73-1.2 Definitions

The following words and terms, when used in this chapter, have the following meanings unless the context indicates otherwise:

"Advocacy" means the ongoing process of assisting the client in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services.

"Assessment" means the ongoing process of identifying and reviewing a client's strengths, deficits, and needs based upon input from the client and significant others including family members and health professionals. The assessment process continues throughout the entire length of service. The assessments are updated periodically based upon availability of client information.

"Case management services" means those services which will assist a Medicaid beneficiary in gaining access to needed medical, social, educational, and other services.

"Client monitoring" means the ongoing review of the provider of the client's status and needs.

"Division of Medical Assistance and Health Services (DMAHS)" means the organizational component of the New Jersey Department of Human Services which is responsible for the administration of the State's medical assistance programs.

“DHS” means the New Jersey Department of Human Services.

"Division of Mental Health Services (DMHS)" means the organizational component of the New Jersey Department of Human Services which is responsible for the administration of the State's mental health programs.

"Division of Youth and Family Services (DYFS)" means the organizational component of the New Jersey Department of Human Services that administers the Title IV-E program of the Social Security Act, 42 U.S.C. §§ 670-679b.

"HCFA" means Health Care Financing Administration of the United States Department of Health and Human Services.

"HCPCS" (Health Care Financing Administration Common Procedure Coding System) means a nationwide three level coding system. Level 1 codes are adapted from codes published by the American Medical Association in the Common Procedure Terminology and are utilized primarily by physicians and independent clinical laboratories. Level 2 codes are assigned by HCFA for physician and non- physician services which are not in the CPT. Level 3 codes are assigned by the State Medicaid Agency and are used for services not identified by the CPT or HCFA assigned codes.

"Juvenile Justice Commission (JJC)" means the agency in, but not of, the Department of Law and Public Safety which is mandated by statute to develop and operate both non-secure residential programs and secure facilities for adolescent juvenile offenders sentenced to the Commission by the New Jersey Superior Court, Family Part, and to provide parole supervision to juvenile inmates released by the New Jersey Parole Board. (See N.J.S.A. 52:17B-17O)

"Service planning" means the process of organizing the outcomes of the assessment in collaboration with the client, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the client's needs, planned services to address these needs, and plans to motivate the client to utilize

services. The service planning process continues throughout the client's entire program length of stay.

"Services linkage" means the referral to and enrollment with other appropriate service providers to address the needs identified in the assessment.

"Targeted case management" under Case Management Program/Mental Health (CMP/MH) is the provision of services targeted to adults and children with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. Case management is for either long-term support (clinical case management) or linkage to other mental health services (liaison case management). Targeted case management services include, but are not limited to: assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support and advocacy.

In "Case management services", substituted "/NJ FamilyCare beneficiary" for "recipient"; in "Clinical case management", substituted "beneficiary" for "client"; rewrote "HCPCS".

END OF SUBCHAPTER 1

SUBCHAPTER 2 CASE MANAGEMENT PROGRAM/MENTAL HEALTH (CMP/MH)

10:73-2.1 Definitions

The following words and terms, when used in this subchapter, have the following meanings unless the context indicates otherwise:

"Clinical case management" means the provision of face-to-face individualized clinical support services, in accordance with N.J.A.C. 10:73-2.11, for a beneficiary who needs consistent contact to ensure that the beneficiary remains:

1. Engaged with the case manager;

2. Stable in his or her individual situation; and

3. Linked to needed services.

"Initial evaluation services" means the initial contact, evaluation, completion of a risk assessment and initiation of services, in accordance with N.J.A.C. 10:73-2.10.

"Liaison case management" means that part of the CMP/MH services which is targeted to a seriously mentally ill individual, adult or child who has been discharged from a State or county psychiatric hospital, psychiatric unit of a general acute care hospital or a specialty hospital, and who requires short- term assistance to ensure linkage to community mental health programs, provided in accordance with N.J.A.C. 10:73-2.12.

"Ongoing support services" means the provision of face-to-face individualized clinical support services for a client who needs such contact, as determined in accordance with N.J.A.C. 10:73-2.4(a)5.

"Risk category" means the three levels of clinical case management involvement, based upon assessed risk of hospitalization, functional level and willingness and/or ability to access needed services. The three risk categories are: high-risk, or intensive case management; at-risk, or supportive case management; and low-risk, or maintenance level case management, as determined in accordance with N.J.A.C. 10:73-2.10.

"Service provider monitoring" means the process of routine follow-up by case manager or by Division of Mental Health Services with the client's service providers to assess whether services have been provided as planned and whether such services meet the client's needs, in accordance with N.J.A.C. 10:73- 2.4(a)4.

"Unit of service," for the purposes of this subchapter, means a continuous face-to-face contact with an enrolled client, or on behalf of an enrolled client, which lasts 15 minutes, not including travel time.

10:73-2.2 Case Management Program/Mental Health (CMP/MH); general

(a) The CMP/MH is under the auspices of the Division of Mental Health Services and is administered jointly with the Division of Medical Assistance and Health Services. It is a program to provide case management services to seriously mentally ill Medicaid/NJ FamilyCare beneficiaries, both children and adults, who do not accept nor engage in community mental health programs and/or who have multiple service needs and require extensive coordination.

1. CMP/MH is for either long-term support (clinical case management) or short-term support (liaison case management).

(b) Case management services are not available to beneficiaries of the Medically Needy Program, except pregnant women, nor beneficiaries served in the DMAHS' Home and Community Based Services Waiver Program, Model Waivers, DDD Waiver, ABC Waiver, Traumatic Brain Injury Waiver, or the Home Care Expansion Program.

1. For information on how to identify a Medicaid/NJ FamilyCare beneficiary, refer to N.J.A.C. 10:49-2, Administration.

10:73-2.3 Individuals targeted to receive CMP/MH services

(a) Clinical case management services under CMP/MH are targeted to children and adults with serious mental illness who are at high risk of hospitalization or deterioration in their functioning and who require an assertive community outreach service to meet their needs. This targeted group is composed of individuals who meet at least two of the following:

1. Have repeated admissions to inpatient services. Priority will be given to persons with two or more admissions to inpatient psychiatric services within a 12-month period, or two or more uses of emergency/screening services within a 30-day time period;

2. Participate in mental health services, but are not receiving additional services which meet the individual's multiple needs, and who require extensive service coordination (for example, individuals who are dually diagnosed as mentally ill and chemical abusing, or children involved with DYFS and school systems);

3. Have a recent history of being a danger to self or others within a time period of three months;

4. Have a history of resistance or non-compliance in use of medication, resulting in a pattern of decompensation and rehospitalization;

5. Are in another service system and in need of assessment and possible treatment prior to linkage to case management (for example, residential, drug and alcohol programs, or shelters for the homeless); and/or

6. Reside with family, in boarding homes, or other residential settings and are not receiving needed mental health services.

(b) Liaison case management services under CMP/MH are targeted to children and adults who:

1. Recently were discharged from a State or county hospital or a general acute-care hospital psychiatric inpatient unit and in need of linkage services to ensure continuity of care with other mental health services; or

2. Have a recent history of a hospitalization as a result of mental illness and dangerousness to self or others.

10:73-2.4 Case management services provided under CMP/MH

(a) CMP/MH services shall include, but shall not be limited to, assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support, and advocacy. These services are described below:

1. Assessment is the ongoing process of identifying, reviewing and updating a beneficiary's strengths, deficits, and needs, based upon input from the beneficiary and

significant others including family members and community and hospital professionals. The assessment process continues throughout the entire length of stay. (See N.J.A.C. 10:73-2.10 for information about beneficiary's risk status.)

2. Service planning is the process of organizing the outcomes of the assessment in collaboration with the client, significant others, potential service providers, and others as designated, to formulate a written service plan that addresses the beneficiary's needs, planned services to address these needs, and plans to motivate the beneficiary to utilize services and remain in the community. The service planning process continues throughout the beneficiary's entire program length of stay.

3. Services linkage is the ongoing referral to, and enrollment in, a mental health and/or non-mental health program. Mental health program linkage means that the beneficiary has completed the mental health program's intake process, that the beneficiary has been accepted for service, and that the beneficiary has effectively participated in the program.

4. Ongoing monitoring consists of both beneficiary monitoring and service provider monitoring by the case manager:

i. Beneficiary monitoring is the ongoing review of the client's status and needs, the frequency of which is contingent upon the beneficiary's risk status and reported changes from the beneficiary, significant others and/or service providers. An update of the service plan may result from the monitoring process to address changing needs.

ii. Service provider monitoring is the process of routine follow-up with the beneficiary's service providers to assess if services are provided as planned and if they meet the beneficiary's needs. Provider monitoring may result in the adjustment of the service plan including provider changes. Service provider monitoring includes the following:

(1) Monitoring the plans, including the medication management plan for beneficiaries in need of such plans;

(2) Coordination of services from multiple providers including calling and coordinating treatment team meetings of a beneficiary's service providers until the beneficiary exits from the CM program.

5. Ongoing support services is the provision of face-to-face individualized clinical support services for beneficiaries who need consistent contact to ensure engagement to the case manager and to help the person maintain stability and remain linked to needed services. It includes support within the beneficiary's natural support system including family, friends, and employers and typically occurs where the beneficiary resides or

frequents. The frequency of support services is contingent upon the beneficiary's risk status and individual needs.

6. Advocacy is the process of assisting the client in receiving all benefits to which he or she is entitled by working toward the removal of barriers to receiving needed services. Beneficiary advocacy is an ongoing activity of the case manager.

10:73-2.5 Requirements for providers participating in CMP/MH

(a) This section lists the specific provisions relevant to a provider who wishes to apply and be approved as a provider of CMP/MH services. N.J.A.C. 10:73-2.6 provides information about service responsibilities of the CMP/MH provider and N.J.A.C. 10:73-2.7 describes the responsibilities of staff members of a CMP/MH provider agency.

(b) The following are the specific provisions for provider participation in CMP/MH:

1. Any agency that wishes to provide CMP/MH services must be certified by the Division of Mental Health Services and under contract as an approved clinical case management and/or liaison provider and must be individually approved as a Medicaid/NJ FamilyCare provider by the New Jersey Medicaid/NJ FamilyCare program.

2. Case management providers under CMP/MH shall comply with general Medicaid/NJ FamilyCare program policies regarding provider participation (see N.J.A.C. 10:49-3.1). Provider entities must be mental health provider organizations who contract with the New Jersey Division of Mental Health Services in accordance with the Community Mental Health Services Act rules, N.J.A.C. 10:37, to provide clinical case management and/or liaison services.

3. Upon notification from DMHS of a certified, under contract CMP/MH provider, the New Jersey Medicaid/NJ FamilyCare program shall forward the appropriate provider enrollment forms to the provider. (See N.J.A.C. 10:49- 3.1, Eligible Providers.)

4. The CMP/MH provider shall receive written notification of approval or disapproval from the Division of Medical Assistance and Health Services.

i. If approved, the CMP/MH provider will be assigned a provider number by the fiscal agent.

ii. The New Jersey Medicaid/NJ FamilyCare program will furnish a provider manual (which includes this chapter, other relevant chapters including N.J.A.C. 10:49 and additional non-regularity material).

10:73-2.6 Service responsibilities of the CMP/MH provider

(a) The CMP/MH provider shall:

1. Provide ongoing support to enrolled CMP/MH beneficiaries, in their own environment, who are at risk of hospitalization or deterioration in function, to enable them to function in the community and to enable them to access other mental health services whenever possible;

2. Provide or arrange for a clinical offsite service capability to enrolled CMP/MH beneficiaries seven days a week;

3. Provide community-based engagement activities, coordination, and integration for enrolled CMP/MH beneficiaries;

4. Provide ongoing, individualized clinical support and monitoring to maintain stability until the beneficiary participates effectively in other needed services; and

5. Seek and accept referrals within provider capacity of beneficiaries from emergency/screening services, local inpatient units and other structured sites, such as homeless shelters or jails, and other referral sites as identified at the local level.

10:73-2.7 Staff members of a CMP/MH provider; responsibilities

(a) The following apply to the case manager (CM):

1. Regarding his or her duties, the CM providing clinical case management services shall:

i. Identify mentally ill beneficiaries in need of CMP/MH services regardless of residence (for example: homeless, shelter, family, boarding home);

ii. Provide clinical assessment of beneficiary's strengths, needs, resources, motivation, level of functioning, mental status, and risk category;

iii. Provide functional assessment of beneficiary's skills (daily living, self-care, social, vocational, etc.);

iv. Provide intensive community based engagement services to maximize the beneficiary's access to services and ability to function adequately and integrate into the community;

v. Provide or arrange for direct clinical intervention;

vi. Provide assessment of the need for crisis intervention, and assistance to providers of psychiatric emergency services in resolving crises;

vii. Provide assessment of substance abuse symptoms;

viii. Provide assessment of available social services, health and mental health resources and the ability of these services to meet each beneficiary's needs;

ix. Develop service plans with the primary goal to motivate beneficiary to access, appropriately use, and remain in community programs;

x. Develop and monitor a plan for medication management for the beneficiary in need of such a plan, in consultation with the county mental health system's psychiatric services components;

xi. Provide ongoing service planning and periodic reviews and revisions of such plans;

xii. Provide access to appropriate services, and ensure the beneficiary receives needed transportation in order to attend services;

xiii. Ensure that the beneficiary engages in the community mental health and non-mental health systems through provision of ongoing individualized clinical support and monitoring;

xiv. Provide clinical consultation with other providers in a beneficiary's network;

xv. Coordinate and integrate services from multiple providers until the beneficiary exits from the CMP/MH. This includes coordination of treatment team meetings of the service providers of a beneficiary in the community.

xvi. Monitor service delivery to meet a beneficiary's changing needs;

xvii. Identify resource gaps and problems of service delivery, and advocate for the resolution of these issues; and

xviii. Provide direct service support to the beneficiary's natural support system, including family, friends, employers, self-help and other natural support groups.

2. Regarding his or her duties, the CM providing liaison case management services shall:

i. Assess, as assigned, inpatients of State and county psychiatric hospitals and short term care facilities and determine patient assignment to either liaison case management or clinical case management services;

ii. Develop discharge plans, in conjunction with other State or county psychiatric hospital or short term care facility treatment team members, for beneficiaries assessed as able or willing to access or engage in necessary community mental health services within 60 days after hospital discharge;

(1) Services rendered while the beneficiary is an inpatient in a State or county psychiatric hospital or psychiatric unit of a general acute care hospital are not billable activities;

iii. Ensure that planned community mental health and non-mental health service linkages occur for beneficiaries assessed as willing or able to link within 60 days after hospital discharge; and

iv. Monitor the beneficiary's linkage to the primary mental health provider for 60 days post-discharge.

10:73-2.8 Prior authorization for clinical case management services

(a) Clinical case management services require prior authorization. (See N.J.A.C. 10:73-2.10(b) for exceptions concerning provision of services for a limited period of time while the prior authorization request is under review.)

1. Liaison case management services do not require prior authorization (see N.J.A.C. 10:73-2.12(c)).

(b) The CMP/MH provider shall request prior authorization from the Division of Mental Health Services, utilizing forms prescribed by that Division.

1. Prior authorization may be for up to 12 calendar months. It is the responsibility of the provider to request prior authorization before furnishing or rendering services. (See N.J.A.C. 10:49-6.1 regarding prior authorization.)

10:73-2.9 Basis of payment for CMP/MH services

(a) Reimbursement for services covered under the CMP/MH shall be determined by the Commissioner of the Department of Human Services. The provider of CMP/MH services shall be compensated on a fee-for-service basis. Reimbursement is based upon HCPCS Codes as specified in N.J.A.C. 10:73-4.

1. The provider shall submit a claim form and identify the services performed by the use of procedure codes based on the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). Three HCPCS codes are assigned for the services provided under CMP/MH. If the services were provided to a child, the provider shall add a modifier (ZC) to the code to signify that the services were provided to a child. For CMP/MH purposes, a child is an individual under the age of 18.

2. The three CMP/MH services that shall be identified on a claim form and submitted for reimbursement are:

i. Initial Evaluation Services.

ii. Clinical Case Management; and

iii. Liaison Case Management.

3. For rules regarding the three case management services (initial evaluation, clinical case management, and liaison case management) see N.J.A.C. 10:73-2.10, 2.11 and 2.12.

(b) A provider may only render one type of case management service to the same beneficiary within the same time period. A beneficiary who receives case management services is entitled to receive other approved mental health services that are rendered by authorized providers.

(c) Each provider shall make a charge for services to all beneficiaries, except as provided by legislation, with the proviso that no charge will be made directly to the Medicaid/NJ Family Care beneficiary.

(d) In no event shall the charge to the New Jersey Medicaid/NJ FamilyCare program exceed the charge by the provider for identical services to other groups or individuals in the community.

1. Payment for CMP/MH services shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose, including, but not limited to, the Home and Community Based Service Waiver programs. Payment for CMP/MH services shall not duplicate payment for case management services which are an integral part of another provider service.

(e) See N.J.A.C. 10:49 for requirements for timely submission of claims.

10:73-2.10 Procedures for providing initial risk assessment and evaluation for CMP/MH services

(a) Under clinical case management, the provider shall conduct an initial risk evaluation on a prospective CMP/MH client during the initial beneficiary contact(s) to determine the "risk category" using a form approved by the Division of Mental Health Services (DMHS). If the prospective beneficiary is found to be eligible for CMP/MH services, he or she shall be assigned to a risk category described in (a)1 through 3 below. The provider shall immediately initiate a request for authorization to provide services beyond the initial evaluation services.

1. High risk (intensive case management involvement) shall be provided to beneficiaries who are in crisis and at immediate risk of decompensation, or who are experiencing situational crises which, without active intervention, would rapidly lead to decompensation and hospitalization.

2. At risk (supportive case management involvement) shall be provided to beneficiaries who exhibit signs of regression, who stop their medication, who are undergoing major transitions from an inpatient or residential treatment setting, or who are withdrawing or refusing needed aftercare services.

3. Low risk (maintenance level case management involvement) shall be provided to beneficiaries who are stable but who have a pattern of psychiatric hospitalization, acute care recidivism, dropping out of mental health and non- mental health services, medication non-compliance, disruption of living, working program and social environments.

(b) The following apply to the initial evaluation services:

1. In order to facilitate the provision of services to the beneficiary while the initial risk evaluation is completed and the request for prior authorization is being evaluated, the initial evaluation services may be provided without prior authorization. Initial evaluation services shall only be provided to beneficiaries who appear to be in need of these services.

2. A claim for initial evaluation services, may be submitted following the initial assessment process performed on a prospective clinical case management beneficiary. Initial evaluation services may be billed once per beneficiary, per provider. In the event a beneficiary changes providers, initial evaluation services can be reimbursed to the new provider.

i. Initial evaluation services may be billed by the same provider for the same beneficiary if there has been a lapse of more than 12 calendar months since the last case management service was provided.

3. During the initial evaluation services, the provider should submit form FD-365 (Prior Authorization Request) to DMHS for future service units.

i. The request for prior authorization must be received by DMHS not later than 45 days after providing the first initial evaluation service for which reimbursement is requested.

4. Reimbursement for initial evaluation services shall not exceed 28 units of service.

10:73-2.11 Clinical case management services under CMP/MH

(a) Clinical case management services include, but are not limited to: assessment, service planning, services linkage, ongoing clinical support and advocacy (see N.J.A.C. 10:73-2.3(a)). These services require prior authorization from the DMHS and claims will not be processed without the appropriate prior authorization approval.

(b) There are three levels (risk category) of clinical case management involvement based upon assessed risk of hospitalization, functional level, and willingness and/or ability to access needed services as defined by DMHS. The three risk categories are: high risk, or intensive case management; at risk or supportive case management; and low risk, or maintenance level case management (see N.J.A.C. 10:73-2.10). The risk levels determine the number of units of service approved by DMHS during a prior authorization period.

1. The following apply in beneficiary hospitalization or residency in nursing facility (NF) circumstances:

i. In the event a clinical case management beneficiary is hospitalized or admitted to a NF during a prior authorization period, the Medicaid/NJ FamilyCare program shall not be charged for CMP/MH services rendered during the hospitalization or residency in a NF.

(1) Upon discharge to the community, prior authorization is continued for a CMP/MH beneficiary if the beneficiary remains in the same risk level and has not exceeded the authorization period. No notice is required but the provider is expected to include this information in the beneficiary's chart.

(2) In the event a reassessment occurs following hospitalization, or residency in a NF, appropriate documentation must be placed in the case file and, if the risk level has changed, a request for prior authorization for the new level of case management services must be forwarded to DMHS, no later than 10 days after discharge. Until then, the case manager must bill for continued services at the previously authorized risk level.

ii. In the event a CMP/MH beneficiary's hospitalization or residency in a NF extends beyond a prior authorization period, the provider shall request authorization from DMHS to provide services post-discharge. Claims for initial evaluation services will not be processed if the beneficiary continues with the same provider. Claims for services post-discharge will not be honored without prior authorization.

2. For services rendered prior to December 1, 1994, each provider shall, within two months following the end of each prior authorization period, complete a reconciliation of services provided and payment received.

i. The reconciliation shall compare the units of service rendered during the authorization "period" and the initial evaluation month with the minimum required units of service during that period. If more units of service were provided than required, no adjustment will be made. If fewer units of service than the minimum were provided, the provider shall calculate the overpayment as follows:

(1) $50.00 shall be used as the hourly rate;

(2) The required units of service shall be determined by multiplying the number of months in the authorization period by the minimum average units of service per month as required under this section. If an initial evaluation month was billed for, seven units of service shall be added to the above calculation which was the required units of service only during the prior authorization period.

(3) The actual units of service provided during the authorization period (including initial evaluation month if applicable) shall be compared with the required units of service calculated above.

(4) The hourly rate shall be multiplied by the excess of required units of service over the actual units of service provided.

ii. In the event it is determined that the provider has received an overpayment, repayment should be forwarded to the Medicaid fiscal agent within 30 days of reconciliation with appropriate documentation.

iii. DMHS shall provide a sample form to reconcile and document services and payment. Whatever reconciliation form is used must be retained by the provider.

iv. Reconciliation and repayment, if applicable, must be completed within two months after the end of the prior authorization period.

Example: Mr. Jones is a client in a State psychiatric hospital whose treatment team is preparing a discharge plan. Mr. Jones is judged not to be able to effectively link with the community mental health system upon discharge and therefore the hospital treatment team incorporates a clinical case manager from an approved provider as part of the team (the XYZ Community Mental Health Center (CMHC)).

Together, the treatment team, Mr. Jones, and significant others prepare the discharge plan and treatment plan. The time spent by the clinical case manager (or liaison, had liaison staff been appropriate) while Mr. Jones is hospitalized is not billable to the Medicaid program.

On January 1, 19xx, discharge is planned for January 25. The clinical case manager initiates a request for prior authorization to the DMHS to begin February 1. Mr. Jones is discharged on January 25. The XYZ CMHC continues to provide clinical case management services and receives the prior authorization from DMHS on February 15, which is effective February 1, through July 31. Mr. Jones has been authorized at the high risk level.

The XYZ CMHC provides the following units of service and bills the following codes:

Period	Units	Code	Reimbursement [FN*]
1/25-1/31	5	Z5004 [FN**]	$350.00
2/01-2/28	8	Z5000	$350.00
3/01-3/31	7	Z5000	$350.00
4/01-4/30	6	Z5000	$350.00
5/01-5/31	6	Z5000	$350.00
6/01-6/30	5	Z5000	$350.00
7/01-7/31	8	Z5000	$350.00
TOTAL	45		$2,450.00

[FN*] This is the reimbursement based upon the HCPCS codes as of the promulgation of this Chapter and is subject to change from time to time.
[FN**] Z5004 is initial evaluation month and therefore no prior authorization is required.

By July 1, the XYZ CMHC initiates a new request for prior authorization to be effective August 1. After July 31, the XYZ CMHC will need to reconcile the payment received ($2,450.00) with the reimbursement earned based upon the number of units of service provided as follows:

REQUIRED SERVICE	
1. Minimum units of service required during initial evaluation month (where applicable)	7
2. Minimum units of service required during each month of prior authorization period based on approved risk level	7
3. Number of months in authorization period	6
4. Minimum units of service required for authorization period (#2 x #3)	42
5. Total required units of service (#1 + #4)	49
6. Actual units of service provided	<45>
7. Excess of units required over <under> units provided	4
The XYZ CMHC provided four fewer units of service than required and therefore must calculate and make repayment as follows:	
RATE/UNIT OF SERVICE	
8. Monthly reimbursement for authorized risk level	$350.00
9. Divide by minimum required units of service	7
10. Rate/Unit of Service	$ 50.00
CALCULATION OF OVERPAYMENT	
Excess of units required over provided (#7 above)	4
x Rate/Unit of service (#10 above)	x $ 50.00

Overpayment $200.00
The XYZ CMHC forwards the overpayment to the fiscal agent by the end of the second month following the authorized period.

10:73-2.12 Liaison case management services under CMP/MH

(a) Services provided under liaison case management shall include, but shall not be limited to:

1. Assessment and determination of need for services;

2. Development of discharge plans;

3. Assurance that mental health and non-mental health linkages occur; and

4. Monitoring of beneficiary linkage to mental health provider.

(b) Services listed in (a)1 to 4 above are reimbursed on a fee-for-service basis, not to exceed 16 units.

(c) Liaison case management services do not require prior authorization.

(d) Liaison case management services may be provided within 60 days of discharge from a hospital or inpatient psychiatric program.

(e) Liaison case management services may be billed for each discharge from a hospital, if services are provided.

(f) Liaison case management shall not be billed in conjunction with any other CMP/MH service.

(g) If the case manager determines during this period of time that the beneficiary will need clinical case management services and the liaison case manager is a certified provider of clinical case management, then the case manager is responsible for completing the risk assessment documentation and submitting a prior authorization request to DMHS as soon as possible but no later than 30 days prior to the end of the liaison services. If the liaison case manager is not a certified clinical case manager, then the liaison case manager must refer the beneficiary to the clinical case manager identified to serve the beneficiary's geographic area as soon as possible, but no later than 40 days prior to the end of liaison services.

(h) The reconciliation process described at N.J.A.C. 10:73-2.11(b)2 with respect to clinical case management shall be required for liaison case management. The minimum average units of service to be provided are two units per month, post hospital discharge.

10:73-2.13 Recordkeeping for CMP/MH services

(a) Case management providers shall keep such individual records as are necessary to fully disclose the kind and extent of services provided to make sure such information is available as the DMAHS or DMHS or its agents, may request.

1. The CMP/MH provider shall maintain the following data in support of all payment claims as required by the rules.

i. The name of the beneficiary;

ii. The name of the provider agency and staff person and the title of the individual providing service;

iii. The dates of service;

iv. The units of service;

v. The length of face-to-face contact (excluding travel to or from beneficiary contact);

vi. The name of individual(s) with whom face-to-face contact was maintained on behalf of beneficiary; and

vii. A summary of services provided.

END OF SUBCHAPTER 2

SUBCHAPTER 3 CARE MANAGEMENT ORGANIZATION SERVICES FOR THE CHILDREN'S SYSTEM OF CARE INITIATIVE

10:73-3.1 Purpose and scope

(a) This subchapter sets forth the manner in which care management organization (CMO) services shall be provided to eligible Medicaid, NJ FamilyCare and Children's System of Care Initiative beneficiaries, and shall apply to all CMO services provided through Title XIX and Title XXI of the Social Security Act, 42 U.S.C. § § 1396 and 1397, or State-funded only programs.

(b) Care management organization services are administered under the auspices of the Department of Human Services (DHS) and its Divisions of Mental Health Services (DMHS), Youth and Family Services (DYFS) and Medical Assistance and Health Services (DMAHS).

(c) All services shall be provided and administered in a manner consistent with all DHS rules and contract obligations.

(d) If a conflict arises between contract requirements and any existing provider rules, the terms set forth in the DHS contract shall prevail.

10:73-3.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context indicates otherwise:

"Adult" means a beneficiary age 21 years or older.

"Children's System of Care Initiative (CSOCI)" means the Department of Human Services initiative, developed to provide a comprehensive approach to the treatment of mental illness in children, adolescents and young adults.

"Care management organization (CMO)" means an independent, community-based organization that combines advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused individual service plans (ISPs) for children, adolescents and young adults transitioning into the adult system

whose needs are complex, requiring intensive care management techniques that cross multiple service systems.

"County Case Assessment Resource Team (CART)" means a team which is part of a county-based interagency system of individual case planning and service system development in which multi-disciplinary teams review cases of children with emotional or behavioral disturbances, who are placed residentially, or at risk of psychiatric hospitalization, to determine if a community-based placement is more appropriate. A CART also promotes partnerships with parents, advocates across all child serving systems and coordinate services.

"Child" means an individual under 18 years of age.

"Contracted system administrator (CSA)" means an administrative organization contracted by, and serving as an agent of, the Department of Human Services to provide administrative services to support the development, management and implement the Children's System of Care Initiative.

"County Interagency Coordinating Council (CIACC)" means the county-based planning and advisory groups composed of individuals from governmental and private agencies that advise the county and the Department regarding children with serious emotional and behavioral disturbances.

"Department of Human Services Children's Initiative Team (DHS CI Team)" means a team consisting of staff from the Department of Human Services, with representation from the Divisions of Medical Assistance and Health Services, Youth and Family Services, and Mental Health Services, which assists the CMO in working with other systems partners.

"Family-friendly services" means services that are accessible, convenient, culturally competent, meet family defined objectives and goals, and are reasonably available to families in the communities in which they live.

"Family support organization (FSO)" means an independent community based organization providing services through a contract with the Department in affiliation with the New Jersey Parents Caucus Family Connections. The FSOs are comprised of family members who are involved or have been involved in the system and who provide direct peer support and advocacy to children and families entering CSOCI.

"Individualized service planning (ISP)" means a process that wraps services and supports around the child/family and provides access to the services they need, delivered in the communities where they live, work and attend school. ISPs are holistic in nature and address areas of everyday living beyond the treatment of mental health symptoms.

"Young adult," for the purposes of the Children's System of Care Initiative, means an individual, at least 18 years of age and under 21 years of age, who had been receiving services prior to becoming 18 years of age, and who demonstrates a clinical need for the continuation of services as part of the transition into adult services.

10:73-3.3 Provider enrollment criteria

(a) In order to participate in the CSOCI as a provider of CMO services, a provider shall apply to, and be approved by, the New Jersey Medicaid/NJ FamilyCare fee-for-service program.

1. Providers shall complete and submit the Medicaid "Provider Application" (FD-20) and the Medicaid "Provider Agreement" (FD-62).

2. The FD-20 and the FD-62 may be obtained from and submitted to:

Unisys
Provider Enrollment
PO Box 4804
Trenton, NJ 08650-4804

3. For additional details, see the Administration chapter, N.J.A.C. 10:49- 3.2, Enrollment process.

(b) All providers of CMO services shall be under contract with the New Jersey Department of Human Services.

(c) All providers shall adhere to all requirements set forth in N.J.A.C. 10:3 and 10:49.

10:73-3.4 CMO responsibilities and services; general overview

(a) Under contract to the Department and working as a systems partner to develop and implement the Children's System of Care Initiative, CMO providers are responsible for:

1. Providing initial and continuing case management services to children and families referred to them by the Department or other designated agent of the Department.

i. Continuing CMO services provided under the Children's System of Care Initiative shall include, but shall not be limited to:

(1) Comprehensive assessment services;

(2) Individual Service Plan (ISP) design and implementation;

(3) Advocacy and family support;

(4) Information management; and

(5) Quality assessment and improvement.

2. Enrolling as presumptive eligibility providers to screen and facilitate the completion of Medicaid/NJ FamilyCare applications, and assist with the determination of eligibility for all CMO beneficiaries;

3. Managing a DHS provided fund to develop community resources to support the child and family;

4. Managing a flexible fund to provide resources and services identified in the child's Individual Service Plan that are not available through other funding or community resources; and

5. Managing the resources provided under the CMO's responsibilities to a financial benchmark developed by DHS.

(b) Each provider shall ensure that no distinction is made with regard to the quality or availability of CMO services to CSOCI enrollees, regardless of the enrollee's eligibility type.

10:73-3.5 Access to services

(a) CMO services shall be available to children, adolescents and young adults who have been determined by the Department, or its designated contracted system administrator (CSA), to require an intensive level of care management due to any one or any combination of the following:

1. Serious emotional or behavioral disturbances resulting in significant functional impairment;

2. The involvement of multiple agencies or systems such as DMHS, DYFS, JJC or the court system;

3. A disruption of a current therapeutic placement;

4. The risk of a psychiatric rehospitalization; or

5. The risk of placement outside the home or community, except for foster care placements if they do not meet any of the above criteria listed in (a)1 through 4 above.

(b) The DHS CI Team or other designated agent of the Department shall refer to all CMO clients. Children and families who may be eligible for CMO services shall include, but shall not be limited to, children currently receiving services from:

1. The Division of Youth and Family Services;

2. The Juvenile Justice Commission or the juvenile court system;

3. Crisis/emergency service providers; and

4. Provider agencies (for example, providers of mental health or related services).

(c) No children, adolescents or young adults shall be referred for CMO services until the immediate crisis is stabilized.

(d) No beneficiary shall be referred for CMO services whose sole diagnosis is substance abuse or developmental disability, if there are no other emotional or behavioral disturbances that require CMO services.

10:73-3.6 Beneficiary eligibility criteria

Children who are eligible for Medicaid/NJ FamilyCare, as well as children who are eligible for services through other DHS programs, and who require CMO care coordination, shall be eligible for CMO services.

10:73-3.7 Processing presumptive eligibility applications

(a) All CMO providers shall be required to enroll as Medicaid/NJ FamilyCare presumptive eligibility providers consistent with requirements at N.J.A.C. 10:49-2.8.

(b) All CMO providers shall be required to assist the child and family in collecting the documentation and completing a Medicaid/NJ FamilyCare application within 30 days of enrollment into the CMO, if this process has not already been initiated by another entity.

10:73-3.8 Enrollment of the beneficiary into CMO services and the initial ISP

(a) The CMO shall initiate enrollment of the child upon receipt of the referral from the Department for its designated agent and shall complete the electronic case record within seven calendar days of receipt of the referral.

(b) The CMO shall begin the initial ISP by contacting the family and holding a face-to-face meeting with the child, adolescent or young adult, and the family or other caregiver within 72 hours of the referral from the CSA or the DHS CI Team.

(c) The CMO shall refer the child, adolescent, or young adult and his or her family or other caregiver(s) to the FSO within the CMO service area for family- to-family support services during this time period.

(d) The initial ISP shall develop an interim plan to stabilize the child and family and address immediate concerns, including, but not limited to:

1. Preliminary crisis management plans to address any crisis situations that may occur prior to the completion of the comprehensive ISP;

2. Child and community safety;

3. Clinical need; and

4. Caregiver needs.

(e) The initial ISP should be completed within seven calendar days of referral from the Department or its designated agent and registered with the CSA within 24 hours of completion.

(f) The CMO shall coordinate and assure initiation of the immediate needed services identified in the initial ISP during the development and completion of the comprehensive ISP.

10:73-3.9 ISP team; members and responsibilities

(a) To complete the comprehensive ISP, the CMO shall be responsible for developing an ISP team, in conjunction with the family member or caregiver, which shall consist of, at a minimum, the following members:

1. A CMO care manager;

2. The child, adolescent, or young adult and the parent or other caregiver;

3. Any interested person the family wishes to include as a member of the team, including, but not limited to, clergy members, family friends, and any other informal support resource;

4. A representative from the FSO, if desired by the family;

5. A clinical staff member who is directly involved in the treatment of the child, adolescent or young adult that the ISP is being developed for, if desired by the family;

6. Representation from outside agencies the child, adolescent, or young adult is involved with, including, but not limited to, current providers of services, parole/probation officers, and/or educators that the child and his or her family/caregiver agree to include on the team; and

7. The DYFS caseworker assigned to the child, if the child is receiving child protection or permanency services from DYFS.

(b) The CMO Care Manager assigned to the child, adolescent or young adult and their family/caregiver shall:

1. Refer the child, adolescent or young adult or the family/caregiver for multi-system or any additional specialized assessments as indicated;

2. Serve as the facilitator of the ISP Team;

3. Actively engage the child and family as full partners in the ISP team, assuring their participation in the assessment, planning and service delivery process;

4. Ensure that all services and care management processes respect the child and family/caregiver's rights to define specific goals and choice of providers and resources;

5. Ensure that all services and resources are family friendly and culturally competent;

6. Ensure that all ISP meetings are conveniently scheduled and located for the family/caregiver;

7. Ensure that the ISP is developed as a collaborative effort of all team members;

8. Ensure that the ISP is approved by each team member, including the family/caregiver and the child, at the team meeting;

9. Ensure that the attendance of the team members and their approval of the ISP are documented in the case record;

10. Ensure that the written ISP is signed, at a minimum, by the CMO care manager, the parent/caregiver and the child, as age appropriate, and placed in the child's file within two weeks of the team meeting;

11. Forward the completed and approved ISP to the CSA, for registration, tracking and initiation of the claims payment authorization process; and

12. Forward the completed and approved ISP to each team member, including the family/caregiver, within one week of the team meeting.

10:73-3.10 Comprehensive ISP; general

(a) The ISP shall include a copy of the DHS confidentiality agreement form signed by all participants to adhere to all rules and procedures governing beneficiary confidentiality.

(b) The ISP shall be comprehensive in nature, strength based, and developed in partnership with the child, adolescent, young adult and the family or other caregivers.

(c) The ISP shall be based on the comprehensive assessments that were completed as indicated by the presenting problems, needs and strengths of the child and his or her family/caregiver.

(d) The ISP shall identify the services that are to be provided and shall ensure that they are provided to the child, adolescent, or young adult in the least restrictive manner possible.

(e) The ISP shall consist of outcome based, short term, interim, and long term goals to address each area of unmet need with measurable goals and time frames, specific individual roles and responsibilities, a crisis/emergency response plan, and a schedule for ongoing review and assessment.

(f) The ISP shall, at a minimum, address areas of unmet need in all areas of the following life domains, as indicated by the multi-system assessment process, including, but not limited to:

1. Child safety;

2. Child risk;

3. Clinical needs;

4. Non-clinical needs, if deemed therapeutic and approved by the ISP team;

5. Permanency planning; and

6. Community safety issues.

(g) Child safety, child risk, permanency planning and community safety issues shall be coordinated with the DYFS worker, who has the primary responsibility for child safety under the Federal child protection mandates contained in Title IV-E of the Social Security Act. DYFS maintains the primary responsibility for the DYFS children.

(h) The comprehensive ISP shall be developed within 30 days of the referral to the CSA for each beneficiary.

(i) The completed ISP shall be submitted to the CSA within 30 calendar days of the referral for registration.

10:73-3.11 Comprehensive ISP; contents

(a) The comprehensive ISP shall contain the following components:

1. The participation of providers and local community partners and the integration of available and appropriate services and resources;

2. The addressing of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable;

3. The coordination of system partner mandates and responsibilities with the assessment plan;

4. The involvement of FSOs, if desired by the family;

5. Planning for permanency, clinical care, and child and community safety (DYFS maintains the primary responsibility for permanency and child safety for the DYFS child.);

6. A community based crisis management plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond care manager response;

7. A plan to develop and purchase those items and/or services necessary to support the individual's needs as determined by the team and included in the ISP;

8. The coordination of applicable services with the physical health insurer;

9. Measurable goals and the criteria to be met to obtain those goals;

10. A plan for transitioning the child, adolescent, or young adult and the family/caregiver from CMO services to a community based, natural support network of services;

11. A plan to maintain enrollment for the child, adolescent or young adult receiving the CMO services on a "no eject/no reject" basis until the defined outcomes and discharge criteria specified in the ISP are met; and

12. The signatures of the CMO care manager, the parent/caregiver and the child, adolescent or young adult receiving the services.

(b) The completed ISP shall be submitted to the CSA within 30 calendar days of the referral for registration.

10:73-3.12 Amendments to the ISP

(a) The CMO is expected to review and update the ISP at least every three months, and more often if needed. The care manager shall be responsible for working with the ISP team to facilitate this process.

(b) As part of the reviewed and amended ISPs, the ISP team may need to change the composition of the team, based on the family requests, to reflect changing circumstances and revised treatment goals.

(c) Revised and amended ISPs shall reflect the review of existing provided services for effectiveness and shall include a determination of whether changes to the ISP are indicated based on the provision of current services and their effectiveness.

(d) The CMO care manager shall have the following responsibilities to the rest of the team for the revised or amended ISPs, as follows:

1. Continuing to engage the child and family as active participants in the assessment, planning and service delivery process;

2. Continuing to serve as the facilitator of the ISP team;

3. Continuing to ensure that subsequent ISP meetings are convenient to the family; and

4. Ensuring that subsequent ISPs are developed as a collaborative effort of all team members. The care manager shall:

i. Ensure that the written plan, and any subsequent amendments to the plan, are approved by each team member, including the family and the child, at the subsequent ISP team meetings and placed in the child's file;

ii. Assure the subsequent revised and amended ISPs are signed, at a minimum, by the CMO care manager, the parent/caregiver, the child, as age appropriate, and submitted to the CSA within seven calendar days of the ISP team meeting; and

iii. Forward the completed and approved revised ISP to each team member.

10:73-3.13 Crisis management

(a) The CMO shall be responsible for assuring that each ISP and subsequent ISP shall identify potential crisis(es) and contain a crisis management plan for each child and family. The crisis management plan shall assure services are available to respond on a 24 hour-a-day/seven-days-a-week basis.

(b) The crisis management plan shall include coordination of the crisis management plan with the CSA crisis management services and available local crisis intervention services.

(c) The CMO shall also maintain the capacity to respond face-to-face as needed to assess the need for additional crisis services that are otherwise not identified in the ISP, to provide support and to facilitate the provision of other crisis or emergency intervention services, as warranted.

10:73-3.14 Community resource development

(a) The CMO shall catalog all available services and community resources to support the ISP design, and shall provide a list of these resources to the CSA for inclusion in the Statewide database that shall be maintained for children's services.

(b) Based on a thorough understanding of the cultural diversity of its service area, each CMO shall identify and develop accessible, culturally responsive services and supports, including affiliations with informal or natural helping networks, such as neighborhood associations determined by the ISP team to be appropriate, which supports the ISP of one or more beneficiaries within the service area of the CMO.

(c) The CMO shall develop policies and procedures for identifying and recruiting appropriate informal community supports in the ISP and for providing supervision and oversight of their activities.

(d) The CMO shall develop and maintain working affiliation agreements or Memoranda of Understanding (MOUs) with all participants in the community service/resource network. These MOUs shall identify specific goals, roles, and responsibilities for collaborative activity.

1. The CMO shall develop working relationships reflected in Memoranda of Understanding with all key service providers, community organizations, and system partners.

(e) The CMO shall include the local FSO as a partner in the resource development and coordination process.

10:73-3.15 Financial management

(a) Under the Children's System of Care Initiative, the care provided and the payment for care is individualized and child centered rather than program and service centered. The CMO has responsibilities, as a systems partner, to assist in the implementation of this principle as outlined in this subchapter and their individual DHS contract.

(b) Financial management and monitoring responsibilities of the CMOs shall include:

1. The design and implementation of Individual Service Plans (ISPs) that shall include a range of services and social supports, some of which will be eligible for reimbursement under Medicaid/NJ FamilyCare or other DHS contracts;

2. The administration of a flexible funding pool for purchasing services and social supports that contribute to the goals of an ISP, but are not reimbursable under Medicaid/NJ FamilyCare program or other DHS contracts;

3. The use of DHS funds to develop a local network of innovative community resources available to ISP through the flexible funding pool, and the community resource fund, organized specifically to contribute to ISP goals and outcomes;

4. The monitoring and tracking of the costs of the ISP in conjunction with DHS and CSA eligibility and other system partners;

5. The reporting of financial outcomes, correlating the clinical outcomes with the financial resources consumed to produce the clinical outcomes; and

6. The tracking and managing of funds consistent with DHS child monthly cost benchmarks.

10:73-3.16 Information management

(a) The CMOs shall establish and maintain an integrated electronic child and family file.

(b) The CMOs shall use the software provided by the CSA to obtain, organize, analyze, and distribute the following information:

1. Records management, including creating and maintaining individual electronic case records;

2. Real time enrollment, electronic assessment and ISP information;

3. Tracking of client status, ISP outcomes, service/resource availability and utilization, and quality of care and cost indicators;

4. Interfacing with the CSA's system, including the transfer of data for the purposes of updating individual electronic case records, facilitating the claims payment process for authorized service requests;

5. Maintaining a registry of service providers practicing within the CMO's area of responsibility, and providing access to this registry as needed; and

6. Reporting, as required by DHS in the CMO contract, to include the capability to report on services provided, payments made, and child and family outcomes by client and/or servicing provider.

10:73-3.17 Quality assessment/evaluation

(a) CMOs shall develop an annual Quality Assessment and Performance Improvement (QAPI) Plan.

(b) In addition to the CMO's own QAPI Plan that shall be incorporated into the CSOCI,

each care management organization shall be evaluated by DHS, or its designated agent, based on various performance measures, including the following:

1. Timeliness of service plan development;

2. Progress towards financial benchmarks;

3. Cultural, ethnic, and linguistic competency;

4. Individual service plan appropriateness;

5. Restrictiveness of living environment;

6. Hospital or CCIS readmission rate;

7. Changes in the level of functioning of the child;

8. Placement stability;

9. Permanency including supporting the DYFS mandates and requirements in this regard;

10. Length of stay in residential treatment centers;

11. Involvement of the child and family; and

12. Consumer satisfaction with the services provided.

10:73-3.18 Staffing requirements

(a) CMO staffing shall include:

1. An administrative staff, to include an executive director;

2. Adequate support staff to effectively perform clerical, financial, quality management, and MIS functions;

3. Direct care staff for clinical operations; and

4. Support for the community resource development function, consistent with DHS

rules, and ISP planning and implementation.

(b) CMO care management staffing ratios shall be:

1. Supervisors to care managers, a 1:8 ratio; and

2. Care managers to families, a 1:10 ratio.

10:73-3.19 Staff qualifications

(a) The Executive Director shall have a Master's degree in a relevant discipline, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, with a minimum of five years' post Master's related supervisory experience in child welfare, children's mental health, juvenile justice, special education, public administration or management or a related public sector human services or behavioral health field.

(b) Supervisors shall have a Master's degree in a relevant discipline, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, with a minimum of two years post Master's related supervisory experience in child welfare, children's mental health, juvenile justice, special education or a related public sector human services or behavioral health field working with at risk children and families.

1. Supervisors shall have experience in clinical assessment and child/adolescent development, with community-based experience preferred.

2. Supervisors shall be clinically and culturally competent/responsive, with the training and experience necessary to manage complex cases in the community across child serving systems. Supervisors shall possess a valid driver's license.

3. Supervisors shall have experience with community relations and resource development. Bilingual ability (such as Spanish/English) is preferred in geographic areas with high concentrations of non-English speaking consumers.

(c) Care managers shall have a minimum of a Master's degree in a related field, such as social work, counseling, psychology, psychiatric nursing, criminal justice or special education, or a Bachelor's degree in a related field and a minimum of one year related experience.

1. Care managers with experience with community relations and resource development are preferred.

2. Bilingual ability (such as Spanish/English) is preferable in geographic areas with high concentrations of non-English speaking consumers.

10:73-3.20 Recordkeeping

(a) Each provider shall maintain all records in accordance with Departmental contract policy (see N.J.A.C. 10:3) and in compliance with appropriate State law and rules (see N.J.A.C. 10:49-9.8).

(b) CMO providers shall keep such individual legible records as are necessary to fully disclose the nature and extent of the services provided.

(c) CMO providers shall also make such information available to DHS, DMAHS, DMHS, DYFS, or other authorized agents, as requested.

(d) The CMO provider shall maintain the following data in support of all CMO fee-for-service claims:

1. The name of the client;

2. The name and title of the individual providing the service;

3. The dates of service;

4. The length of time that the service was provided;

5. The length of face-to-face contact (excluding travel to or from client contact); and

6. The name of individual(s) with whom contact was maintained on behalf of the client.

10:73-3.21 Reimbursement methodology for CMO services

(a) Reimbursement amounts for services provided by CMOs shall be specified in the contracts negotiated between the Department of Human Services and the CMOs.

(b) Claims for CMO services shall be submitted on a monthly fee-for-service basis for the care management component of the CMO's services.

1. The first month that a beneficiary begins receiving services from the CMO, the CMO shall bill for that month, regardless of the specific initial date of services.

2. The month that a beneficiary ceases receiving services from the CMO, the CMO shall not bill for that month, regardless of the specific termination date.

(c) Providers shall seek reimbursement by submitting a HCFA-1500 claim form, in accordance with N.J.A.C. 10:49.

1. HCPCS code Z5008 shall be billed monthly for Care Coordination services provided by care management organizations, provided to beneficiaries as part of Children's System of Care Initiative. (See N.J.A.C. 10:73-4.2)

10:73-3.22 Fair hearings

Providers shall have the right to request a Medicaid/NJ FamilyCare fair hearing in accordance with N.J.A.C. 10:49-10.3.

END OF SUBCHAPTER 3

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:73-4.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant to Medicaid/NJ FamilyCare case management services and care management organization services and must be used when filing a claim.

1. The responsibilities of the case management services provider when rendering services are listed in N.J.A.C. 10:73-2.

2. The responsibilities of the care management organization services provider when rendering services are listed in N.J.A.C. 10:73-3.

3. "P" is listed under Ind (indicator) which means that prior authorization is required.

4. "ZC" is listed under Mod (modifier) which means that service is rendered for children.

5. HCPCS codes Z5000 through Z5004 shall not be billed for services rendered after December 1, 1994.

10:73-4.2 HCPCS codes for case management services

Ind	HCPCS Code	Mod	Description	Maximum Fee Allowance
P	Z5000		High Risk Intensive Case Management Program/Mental Health (CMP/MH), Adults, Monthly	$350.00
P	Z5000	ZC	High Risk Intensive Case Management Program/Mental Health (CMP/MH), Children, Monthly	$350.00
P	Z5001		At Risk Supportive Case Management	$175.00

			Program/Mental Health (CMP/MH), Adults, Monthly	
P	Z5001	ZC	At Risk Supportive Case Management Program/Mental Health (CMP/MH), Children, Monthly	$175.00
P	Z5002		Low Risk Maintenance Case Management Program/Mental Health (CMP/MH), Adults, Monthly	$100.00
P	Z5002	ZC	Low Risk Maintenance Case Management Program/Mental Health (CMP/MH), Children, Monthly	$100.00
	Z5003		Liaison Case Management Program/Mental Health (CMP/MH), Adults, Monthly	$100.00
	Z5003	ZC	Liaison Case Management Program/Mental Health (CMP/MH), Children, Monthly	$100.00
	Z5004		Initial Evaluation Month, Case Management Program/Mental Health (CMP/MH), Adults	$350.00
	Z5004	ZC	Initial Evaluation Month, Case Management Program/Mental Health (CMP/MH), Children	$350.00
	Z5005		Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH), Adults	$ 12.50
	Z5005	ZC	Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH), Children	$ 12.50
	Z5006		Clinical Case Management Program/Mental Health (CMP/MH), Adults	$ 12.50
	Z5006	ZC	Clinical Case Management Program/Mental Health (CMP/MH), Children	$ 12.50
	Z5007		Liaison Case Management Program/Mental Health	

			(CMP/MH), Adults	$ 12.50
	Z5007	ZC	Liaison Case Management Program/Mental Health (CMP/MH), Children	$ 12.50
P	Z5008		Care Coordination Services for the Children's System of Care Initiative; CMO Services for Children, Adolescents, and Young Adults; (Monthly)	Contract Pricing

APPENDIX A

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages shall be distributed to providers and filed with the Office of Administrative Law.

For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
PO Box 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
PO Box 049
Trenton, New Jersey 08625-0049